FOR DISCUSSION – 4-02-04

# Medi-Cal Redesign

## Mental Health Stakeholder Meeting

## Sacramento – March 25, 2004

**FOR DISCUSSION ONLY**

This is a summary of the first Mental Health Medi-Cal stakeholder meeting held on March 25, 2004 in Sacramento as part of the Medi-Cal Redesign Process. It is divided into three sections:

**Section 1 – Redesign Overview and Stakeholder Meeting Goals**
**Section 2 – Presentations and Stakeholder Comments**
**Section 3 – Other Issues and Topics for Future Meetings**

### Section 1 – Redesign Overview and Stakeholder Meeting Goals

California is seeking federal approval to redesign Medi-Cal in order to contain costs while avoiding deep cuts in eligibility or benefits. The California Health and Human Services Agency has begun a process to obtain stakeholder input regarding potential reform strategies. As part of this stakeholder process, the Department of Mental Health (DMH) is facilitating obtaining stakeholder input on issues specific to specialty mental health services. The specialty mental health input process facilitated by DMH will provide recommendations to Medi-Cal Redesign workgroups. The goals of the stakeholder meetings are:

1. Provide feedback on ideas for discussion compiled from discussions with constituents
2. Identify additional strategies for Medi-Cal specialty mental health services
3. Provide input to the Medi-Cal redesign workgroups

### Section 2 – Presentations and Stakeholder Comments

DMH presented the goals of the Medi-Cal Redesign, anticipated elements of the redesign process and explained the roles of the

California Health and Human Services Agency and Foundation co-sponsors, the Department of Health Services as lead department and the role of DMH as facilitator of the input process regarding specialty mental health services. DHS has five stakeholder groups and input from the mental health stakeholder process will be shared with these workgroups.

Since the Administration has proposed options to increase state flexibility regarding federal requirements for the Early and Periodic Screening, Diagnosis and Treatment Program, information was provided about the specialty mental health benefits in this program. Stakeholders then discussed strategies and options concerning this benefit. Stakeholders offered the following ideas, strategies and concepts. The comments of participants have been combined; where more than one stakeholder offered similar comments, only one is reported here to avoid unnecessary duplication.

## A. EPSDT

- EPSDT is not something for which the State should seek a waiver. MHPs are not serving youth who do not benefit from their services. Untreated youth end up as expensive adult clients

- Narrowing eligibility criteria would just change where youth get seen – more youth would go to primary care, juvenile justice, special education (AB 3632) etc. Restricting services for children with serious emotional disturbances would be a mistake—we need to open up eligibility, not restrict it

- Emphasize the EPSD of the EPSDT program and focus on prevention and earlier intervention rather than narrowing the definition. We should not have a “fail-first” system

- Need to do an assessment of unmet need for children’s services

- Look at moving from more traditional therapies (i.e., play therapy) to more evidence-based practices

- Make AB 3632 youth eligible for Medi-Cal – this was done in New Jersey

- Focus on increasing FFP

- Move toward more home and community-based services rather than group homes and institutional care for youth. We are still placing more youth in high-level group homes when there is no evidence that it is effective. Need to offer home-based care and respite so people can keep their children at home

- Institute a provider quality assurance tax (which then becomes eligible for FFP and comes back to providers through an increased rate)

- Many suggestions will raise costs. MHP service costs are currently very high. We are not really "managing" care and costs. Perhaps it is time to control costs by capitation

- Controlling costs through audits is not appropriate

- Aligning Mental Health Medi-Cal with the private sector is not appropriate for youth with serious emotional disturbances (SED). Youth with SED need more than is available in the private sector. The private sector does not treat these youth; that is why they are in the public sector. If youth with SED do not get what they need, costs in other sectors ( physical health care, juvenile justice, child protective services, special education) are impacted.

- Share of cost for pharmacy would result in some youth not getting needed medications

- Need to find a way to increase eligibility for youth in the juvenile justice system – Establish eligibility for youth in detention awaiting adjudication

- Facilitate service delivery for individuals placed out of county. This is particularly critical in rural areas

Following the discussion of the EPSDT benefit, the group moved to a discussion of other changes that would improve services and systems. DMH presented some ideas compiled from discussions with constituents. These ideas, together with stakeholder comments are presented here. The comments of participants have been combined; where more than one stakeholder offered similar comments, only one is reported here to avoid unnecessary duplication.

## B. Other Mental Health Issues

### Principles

- Changes should be made with recovery philosophy in mind
- CA should take leadership in "pushing back" with CMS regarding promoting recovery
- We need to look at continuity of care and work on wellness rather than illness
- Community living is the goal, independent living is the dream
- Build "flags" within the mental health system so there are early warning signs of system problems
- MH should look at a Home and Community-Based Waiver
- We need more stringent protections for individuals with mental illness; consumers should not be victimized. Be careful not to lose protections as we look at trying to get waivers on new federal regulations
- Try pilots to test out new ideas to see if they really will be cost effective
- Don't change something that will result in higher costs over the long term

- Waivers require a cost-effectiveness test – We should do whatever we can without waivers.

**Eligibility**

- Make it easier for potentially eligible individuals to get on and stay on Medi-Cal

**Benefits - Services**

- Substitute lower cost services for higher cost services (i.e., peer services and other community-based services for institutional services).

- Increase ability to get more Federal Financial Participation

    a. Add employment support, such as job development and coaching to the Medi-Cal State plan (Arizona has done this)

    b. Add peer support services to State Plan

        i. This has been done in Georgia, North Carolina and Hawaii
        ii. CA should develop its own model which preserves the self support and recovery aspects of these services

    c. Include coverage for individuals with substance abuse and mental illness; create the ability to provide integrated treatment. There are tremendous advantages for the whole health care system when people receive integrated treatment for both conditions. This can be done for youth under EPSDT and this could serve as a model

    d. Obtain a waiver of the IMD exclusion for free-standing acute psychiatric hospitals

        i. Will this encourage more hospitalization/institutionalization?
        ii. Eliminating the IMD exclusion, even just for free-standing acute hospitals, may not fit with Olmstead

iii. IMD exclusion is a disincentive and helps to promote smaller community-oriented programs

**Pharmacy Benefit**

- Co-payments for medications would result in clients not getting needed medication. This is not the place to increase "personal responsibility".

- Eliminating coverage for atypical psychotropic medications would result in more clients being re-institutionalized. We must protect this coverage

- Exempt all anti-psychotic medications from the six-medication limit for TARs

- CA should take leadership role and aggressively negotiate large price reductions with pharmaceutical companies

**Financing and Administration**

- Eliminate requirement for UMDAP for Medi-Cal beneficiaries

- Flexible financing, like the cash and carry concept promotes self-determination and choice. However, would this require a capped amount per client? Is there flexibility if someone is having a bad time and needs more services? There is usually a trade off between flexibility and dollars—more flexibility, capped funding

- Review, streamline administrative requirements

- Obtain exemption from new managed care regulations

- Compliance demands move us more toward traditional approaches than recovery approaches

    a. Try to reduce costs of compliance
    b. Clarify requirements

c. Provide samples of acceptable documentation and procedures
d. Start a working group to simplify the forms and compliance processes

**Section Three – Other Issues and Agenda for Second Meeting**

Several themes emerged during the input process:

- Don't narrow definition of EPSDT eligibility
- When clients don’t get their mental health needs met, the impact is on other systems such as jails, primary health, schools, child protective services, special education, etc.
- We still have many unmet mental health needs in CA
- Changes should support recovery and community-based services
- Changes should support practices and services that have been shown to be effective in achieving desired outcomes
- We have made a number of changes in the last few years--let's wait and see the results before we make more changes
- We need to continue to increase FFP
- Don't use audits as the way to control costs
- Compliance is getting very costly and we need some help with this
- Aligning benefits with the private sector is not appropriate for individuals with serious mental illness
- Be careful that a new waiver doesn't prevent us from increasing FFP due to cost-effectiveness requirements

DMH will provide a summary of all of these comments to DHS as part of their stakeholder process. Between now and the next stakeholder meeting DMH will provide an analysis of the strategies proposed at this meeting and by other constituents for discussion at the next meeting. Comments and questions can be emailed or faxed to Nancy Mengebier: email address: nmengebi@dmhhq.state.ca.us)

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Further information about the Medi-Cal Redesign process can be found at:

www.medi-calredesign.org

The next DMH stakeholder meeting will be held on April 21, 2004